Preliminary Data Requirements for the Medicare Prescription Drug Plan Price Comparison Tool on www.medicare.gov

Revised Draft: April 26, 2005

Objective:

The following pages contain preliminary guidance to prospective Medicare prescription drug plans regarding additional data submission requirements for the Medicare Prescription Drug Plan Comparison tool that will be housed on www.medicare.gov. Both stand alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug (MA-PDs) plans will be required to submit these data to CMS and these data will be posted on www.medicare.gov. The purpose of the data is to enable people with Medicare to compare, learn, select and enroll in a plan that best meets their needs. The database structure provides the flexibility to design and communicate plan design, formulary and pharmacy network information to people with Medicare by displaying program contact and pricing information at the network pharmacy level.

The notice of this data requirement was published in the Federal Register on April 22, 2005; the notice can be viewed by visiting the following URL: http://www.cms.hhs.gov/pdps/PriceCompareFederalRegister.txt.

Questions regarding this document can be submitted via email to both tdudley@cms.hhs.gov and koh@cms.hhs.gov or via land mail to the following address:

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Timeline for Data Submissions:
The initial public release of the pricing data on www.medicare.gov is tentatively scheduled for October 13, 2005. In order to be properly prepared for this released date, there will be several electronic test data submissions required by all prospective plans. The timeline for these electronic test data submissions is as follows:

- 5/16/2005 - Post data requirements on www.cms.hhs.gov for prospective plans
- 7/15/2005 - Plans submit electronic test pricing data (not thru HPMS)
- 7/16/205 – 8/15/2005 – CMS to analyze test pricing data submitted by prospective plans
- 8/15/2005 – CMS to send data analysis to all prospective plans
- 8/29/2005 – Prospective plans submit corrected electronic pricing data to CMS
- 9/16/2005 – Approved plans submit electronic pricing data to CMS for final testing (Not for public reporting)
- 10/6/2005 – Approved plans submit electronic pricing data files that will be released on 10/13/2005 on www.medicare.gov.

Details regarding the actual file layout and file submission procedure will be posted on www.cms.hhs.gov no later than May 16, 2005.

Table of Contents for Sample Data File Layouts and Questions:

Note: field sizes identified with an * will be updated at a future date.

DATA VALIDATION

All plan submissions that contain data submitted to HPMS will be validated against the existing HPMS dataset. Any submissions which fail this validation will be rejected. Upon rejection, plans will be notified of the rejection and the reason(s) for that rejection. Plans will have 24 hours to resubmit corrected data.

In the case of validation or other submission errors, to prevent incorrect data display, affected plans will be temporarily deactivated from the tool pending corrected data submission or plan election to utilize last successful data submission.

FORMULARY FILE

Field Name	Type(Size)	NULL	Field Description
CONTRACT_ID[1]	Char(5)	NOT NULL	References Organization's Contract Number assigned by CMS
FORMULARY_ID[1]	Char(8)	NOT NULL	Unique Identifier
NDC[1]	Char(11)	NOT NULL	11 digit
TIER_LEVEL_VALUE[1]	Number(2)	NOT NULL	Defines the Cost Share Tier Level Value Associated with the NDC. Assumption is that the NDC is assigned to one tier value. These values are consistent with the selection of value options available to data entry users in the Plan Benefit Package software. If no Tier Level Value applies, enter '1' as the value for this field.
FORMULARY_VERSION[1]	Number(5)	NOT NULL	Unique version ID assigned to this formulary. The version # will be incremented by one for each new submission. This will be synchronized with HPMS
EFFECTIVE_DATE[1]	DATE	NOT NULL	CGI-AMS formulary review field; no default values
QUANTITY_LIMIT_AMOUNT_YN[1]	Char(1)	DEFAULT 0, NULL	Does the NDC have a quantity limit other than a 30-day or 34-day limit?
QUANTITY_LIMIT_AMOUNT[1]	Number(3)	NULL	If Yes to Quantity_Limit_Amount_YN, enter the quantity limit unit amount. The units for this amount may be defined as number of pills, number of injections, etc. If a limit other than 30 or 34 days does not apply, leave this field blank.

Field Name	Type(Size)	NULL	Field Description
QUANTITY_LIMIT_DAYS[1]	Number(3)	NULL	Enter the days associated with the quantity limit. If a limit other than 30 or 34 days does not apply, leave this field blank.
PRIOR_AUTHORIZATION_YN[1]	Char(1)	DEFAULT 0, NOT NULL	Is prior authorization required for the NDC?
STEP_THERAPY_TYPE_GROUP_NUM[1]	Number(2)	DEFAULT 0, NOT NULL	Number of step therapy drug treatment groups, in which the NDC is included. If Step Therapy does not apply to this drug, then leave this field blank.
STEP_THERAPY_TYPE_GROUP_DESC_X[1]	Varchar2(100)	DEFAULT 0, NOT NULL	Description of step therapy drug treatment group. Field should be repeated in the record based upon number of groups declared in Step_Therapy_Type_Group_Num If Step Therapy does not apply to this drug, then leave this field blank.
STEP_THERAPY_TYPE_GROUP_STEP_X[1]	Char(3)	DEFAULT 0, NOT NULL	Step number within the sequence for this Step Therapy Group

[1] These fields will be used to validate plan submissions for plan finder with HPMS collected data.

Notes:

- This file will provide the tier information by NDC.
- An organization may submit multiple formulary files.
- A formulary file can be assigned to multiple plans for the organization.
- A formulary must be assigned to each of the organization's plans.
- As the plan selector application is primarily designed to provide beneficiaries with information to select a drug plan that meets their needs and not a tool for current drug plan enrollees to seek information about their plan, this tool will disregard the 60-day notice window required when a drug changes tiers. Thus, a tier will display in its new tier prior to the expiration of the 60-day notice window. Plans are required to notify all current plan enrollees about any formulary changes before the changes are implemented.

- Organizations will submit the formulary as described above for all covered NDCs in the plan's formulary. Fields available in HPMS will be subject to Data Validation described above.

Submission Frequency: Organizations can submit updates to this file on a monthly basis after receiving approval of any formulary changes from CMS. Any changes submitted in this file must be coordinated with the formulary approval process submitted through HPMS each month. If an organization does not have any formulary changes for a given month, they will be required to certify that there are no updates. In the case of no updates, the previous month's formulary data will be used.

PLAN MASTER

Organization will NOT submit this file.

Please Note: grayed out records will be collected from HPMS database

Field Name	Type(Size)	NULL	Field Description
CONTRACT_ID	Char(5)	NOT NULL	References Organization's Contract Number assigned by CMS
PLAN_ID	Char(5)*	NOT NULL	Unique Plan Identifier assigned by CMS
SEGMENT_ID	Char(5)*	NOT NULL	Plan Segment ID only for local MA-PD plans assigned by CMS (if applicable)
FORMULARY_ID	Char(8)	NOT NULL	References Formulary For the Plan
PLAN_PREMIUM_D	Currency(8)*	NOT NULL	Monthly premium for part D drug benefit
PLAN_PREMIUM_C	Currency(8)*	NOT NULL	Monthly premium for part C drug benefit
PLAN_DEDUCTIBLE_NO_SUBSIDY	Currency(8)*	NOT NULL	Deductible to be met
PLAN_DEDUCTIBLE_PARTIAL_SUBSIDY	Currency(8)*	NOT NULL	Deductible to be met.

Notes:

- This file will provide general information about each plan, such as which of the organization's formulary files to reference.
- This file will be provided by HPMS directly. Organizations need NOT submit separate files for plan selector application.
- There can be multiple plan master files per organization.
- There should be one record per plan.

Submission Frequency: This file will be updated by HPMS on a monthly basis.

BENEFICIARY COST

Field Name	Type(Size)	NULL	Field Description
CONTRACT_ID [1]	Char(5)	NOT NULL	References Organization's Contract Number assigned by CMS
PLAN_ID[1]	Char(5)*	NOT NULL	References Plan Identifier assigned by CMS
SEGMENT_ID[1]	Char(5)*	NOT NULL	Plan Segment ID only for local MA-PD plans assigned by CMS (If applicable)
COVERAGE_LEVEL[1]	Number(1)	NOT NULL	Identifies what level (1 = No Subsidy Copay/Coinsurance, 2 = No Subsidy Coverage Gap, 3 = No Subsidy Catastrophic)
TIER_LEVEL_VALUE[1]	Number(2)	NOT NULL	References Tier_Level_Value from Formulary File
DAYS_SUPPLY[1]		NOT NULL	Identifies for which days supply this cost structure applies (1 = 30 days, 2 = 90 days, 3 = other)
COST_TYPE_PREFERRED[1]	Number(1)	NOT NULL	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_PREFERRED[1]	Float (8)	NOT NULL	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_PREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.

Field Name	Type(Size)	NULL	Field Description
COST_MAX_AMOUNT_PREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** • Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_PREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). • Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_PREFERRED	Float(8)	DEFAULT 0, NOT NULL	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.
COST_TYPE_NONPREFERRED	Number(1)	DEFAULT 0, NOT NULL	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_NONPREFERRED	Float (8)	DEFAULT 0, NOT NULL	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_NONPREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:**

Field Name	Type(Size)	NULL	Field Description
			• Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_NONPREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_NONPREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_NONPREFERRED	Float(8)	DEFAULT 0, NOT NULL	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.
COST_TYPE_MAILORDER	Number(1)	DEFAULT 0, NOT NULL	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)

Field Name	Type(Size)	NULL	Field Description
COST_AMOUNT_MAILORDER	Float (8)	DEFAULT 0, NOT NULL	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_MAILORDER	Currency(8)	DEFAULT 0, NOT NULL	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_MAILORDER	Currency(8)	DEFAULT 0, NOT NULL	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_MAILORDER	Currency(8)	DEFAULT 0, NOT NULL	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount. **Examples:** • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the

Field Name	Type(Size)	NULL	Field Description
			beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_MAILORDER	Float(8)	DEFAULT 0, NOT NULL	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.
COST_TYPE_MAILORDER_NONPREFERRED	Number(1)	DEFAULT 0, NOT NULL	Define whether member cost is copay or coinsurance. (1 = copay, 2 = coinsurance)
COST_AMOUNT_MAILORDER_NONPREFERRED	Float (8)	DEFAULT 0, NOT NULL	Member cost. (Examples: 10 for $10 copay, .25 for 25% coinsurance)
COST_MIN_AMOUNT_MAILORDER_NONPREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Minimum member cost. This would be applied where the total cost of the drug is less than the beneficiary's copay, or where the beneficiary's coinsurance amount is below a plan defined minimum. **Examples:** • Copay = $10. Total drug cost = $4.73. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though that is greater than the total drug cost. • Coinsurance = .25, Total drug cost = $10. If the COST_MIN_AMOUNT value is defined as $10, beneficiary will be charged $10 even though the defined cost share would have been $2.50.
COST_MAX_AMOUNT_MAILORDER_NONPREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Maximum member cost. This would be applied where the beneficiary's defined contribution is greater than a pre-arranged maximum. **Examples:** Coinsurance = .25, Total drug cost = $200. If the COST_MAX_AMOUNT value is defined as $40, beneficiary will be charged $40 even though the defined cost share would have been $50.
COST_THRESHOLD_MAILORDER_NONPREFERRED	Currency(8)	DEFAULT 0, NOT NULL	Total drug cost cost-share threshold. This would apply where the total cost of the drug is greater than a pre-defined threshold value, and the beneficiary is to be assessed and additional cost share contribution amount.

Field Name	Type(Size)	NULL	Field Description
			Examples: • Copay = $10. Total drug cost = $73, COST_THRESHOLD = $50, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $14.60: $10 + (($73 - $50) *.2). Copay = $10, Total drug cost = $50. COST_THRESHOLD = $0, COST_THRESHOLD_OVERAGE_SHARE = .2. In this case, the beneficiary will be charged $20: $10 + ($50*.2).
COST_THRESHOLD_OVERAGE_SHARE_MAILORDER_NONPREFERRED	Float(8)	DEFAULT 0, NOT NULL	Member cost share for threshold overage amount. This is the amount a member will be charged in addition to the COST_AMOUNT when the total drug cost exceeds the value defined by COST_THRESHOLD. See examples above.

[1] These fields will be used to validate plan submissions for plan finder with HPMS collected data.

Notes:

- This file will be used to determine beneficiary cost for each plan. Each record will be a calculation applied to specific pricing data identified by the plan's pharmacy cost file.
- There should be at least 3 records per tier/per plan, each corresponding to the beneficiary costs for each level of coverage.
- There should be at least 1 and at most 3 records per tier/per plan/per coverage level to account for days supply.
- The 24 columns for COST (6 per given location) reflect the basic ways to determine beneficiary cost share.
- Copay/Coinsurance for LIS population will be the lesser of the statutory copay or the Copay/Coinsurance cost for the No Subsidy population.
- Copay/Coinsurance for Partial Subsidy population will be the lesser of 15% or the Copay/Coinsurance cost for the No Subsidy population.
- Plans will submit this file in its entirety. Fields also available in HPMS (identified by a [1] above) will be subject to Data Validation described above.
- Non-applicable fields should be zeroed out.

Submission Frequency: This file may be updated on a monthly basis pending CMS approval of any changes. If no submission is made, previous submission will be utilized.

REFERENCE PRICING

Field Name	Type(Size)		Field Description
CONTRACT_ID[1]	Char(5)	NOT NULL	References Organization's Contract Number assigned by CMS
PLAN_ID[1]	Char(5)*	NOT NULL	References PLAN_ID that this pharmacy cost file serves assigned by CMS
SEGMENT_ID[1]	Char(5)*	NOT NULL	Plan Segment ID only for local MA-PD plans assigned by CMS (If applicable)
NDC	Char(11)	NOT NULL	11-digit NDC of the drug for which reference pricing should apply
NDC_REFERENCE	Char(11)	NOT NULL	11-digit NDC of the drug whose price and cost should be referenced
REFERENCE_TYPE	Number(1)	NOT NULL	Type of Reference Fee to be applied, 1-Flat Fee, 2-Percentage Fee
REFERENCE_AMOUNT	Float(8)	NOT NULL	Amount of Reference Penalty to be assessed.

[1] These fields will be used to validate plan submissions for plan finder with HPMS collected data.

Notes

- This is an optional table. Null values apply only when submitted.
- There should be one record per plan, where applicable.
- The reference pricing calculation increases beneficiary's estimated copay/co-insurance amount by applying either a fixed or percentage fee in addition to the copay of the referenced drug.
- The reference amount can be either a fixed dollar amount OR a percentage of the difference of the total drug cost of the original and reference drugs. For example, with a reference fee of 100%, beneficiary's copay would be $25 if a brand drug priced at $40 is selected over a direct generic priced at $20 with a $5 copay (i.e., $40 brand cost - $20 generic cost + the $5 copay for the generic medication).

Submission Frequency: Where applicable, organizations will be required to submit reference pricing monthly.

PHARMACY COST

Field Name	Type(Size)	NULL	Field Description
CONTRACT_ID	Char(5)	NOT NULL	References Organization's Contract Number assigned by CMS
PLAN_ID	Char(5)*	NOT NULL	References PLAN_ID that this pharmacy cost file serves assigned by CMS
SEGMENT_ID	Char(5)*	NOT NULL	Plan Segment ID only for local MA-PD plans assigned by CMS (If applicable)
PHARMACY_NUMBER	Char(12)	NOT NULL	12-digit Pharmacy Number (7 digit NABP pharmacy number with five preceding zeroes).
PRICE_ID	Number(4)	NOT NULL	References the Pricing File to be used at this pharmacy.
BRAND_DISPENSING_FEE	Currency(8)	NOT NULL	In addition to the ingredient cost (product cost) at the point of sale.
GENERIC_DISPENSING_FEE	Currency(8)	NOT NULL	In addition to the ingredient cost (product cost) at the point of sale.
PREFERRED_STATUS	Number(1)	DEFAULT 0, NOT NULL	Yes/No defines whether pharmacy is preferred or non-preferred pharmacy.

Notes

- There should be one pharmacy cost submission per plan.
- There should be one record per network pharmacy.

Submission Frequency: Organizations will be required to submit pricing on a weekly basis. If no updates are required, Organizations will be required to certify that there are no updates. In the case of no updates, the previous week's pricing data will be used.

PRICING FILE

Field Name	Type(Size)	NULL	Field Description
CONTRACT_ID	Char(5)	NOT NULL	References Organization's Contract Number assigned by CMS
PRICE_ID	Char(4)	NOT NULL	Price File Grouping Number
NDC	Char(11)	NOT NULL	Any 11 Digit NDC representing the drug/dosage combination
UNIT_COST	Currency(8)	NOT NULL	Unit cost for given NDC less dispensing fee.

Notes:

- This file determines the base unit cost of an NDC in a given pricing regime.
- Price_ID will be assigned by CMS (through plan selector data vendor).
- There can be multiple pricing files per organization.
- The pricing file is applied to the plan through the Pharmacy Cost file.
- Pricing data must be submitted for all drugs covered on a plan's formulary.

Submission Frequency: Organizations will be required to submit pricing on a weekly basis. If no updates are required, Organizations will be required to certify that there are no updates. In the case of no updates, the previous week's pricing data will be used.

Submission Notes: For pricing display, the tool will display one cost for all NDCs of a given drug/dosage combination. Organizations will submit records as described above with unit costs for only one of the several NDCs for a given drug/dosage irrespective quantity. For example if LIPITOR 40MG TAB has 7 NDCs reflecting different package sizes, an organization need only submit one NDC and unit cost for LIPITOR 40MG TAB. An organization should choose the most commonly filled NDC in their plan as a proxy for the given drug/dosage combination.

For formulary drugs and generics, organizations will submit unit cost pricing as described above. For non-formulary drugs, organizations may elect to submit pricing. If no pricing is submitted, the unit cost will be approximated based on AWP pricing minus a standard discount between 10% and 13% plus a standard dispensing fee.

All prices submitted will be subject to periodic audit by CMS against submitted claim data.